IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 21, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, Idaho 83687

Provider #13G001

Dear Ms. Broetje:

On **August 29, 2008**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003749

Allegation #1: Body checks are not conducted on individuals after they engage in elopement behavior.

Findings: An unannounced on-site complaint investigation was conducted from 8/25/08 through 8/29/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

No less than 10 individuals were selected for review. Ten individuals' records documented they (the individuals) engaged in elopement behavior. The individuals' Behavior Reporting Forms (BRFs), dated 8/5/08 - 8/25/08, were compared to their medical records which showed head-to-toe body checks were conducted after the individuals engaged in elopement behavior. One individual's record showed he refused to allow the nurse to complete the check after the elopement but the body check was completed the following morning.

Additionally, individuals were not noted to engage in elopement behavior during no less than 5 hours and 27 minutes of observation. Interviews were conducted with direct care and nursing staff throughout the investigation.

All staff reported that it was a standard procedure to complete a body check after individuals eloped from the living unit or facility.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility's abuse policy does not address procedures to be followed if the alleged staff is the Administrator or Program Director.

Findings: An unannounced on-site complaint investigation was conducted from 8/25/08 through 8/29/08. During that time, review of the facility's policies and procedures and interviews with facility staff were completed with the following results:

The facility's Abuse Prevention policy, dated 4/11/08, did not include procedures to be followed if the Administrator was the staff person accused of abuse. Therefore, the policy did not identify who was responsible to perform no less than 7 duties that were assigned to the Administrator including immediate notification, determining whether abuse occurred based on the investigation report, ensuring appropriate corrective action was taken, working with outside providers, getting the written report, notifying personnel to return to work, and concluding the investigation.

When asked, the Administrator stated during an interview on 8/24/08 from 12:00 - 12:35 p.m., the abuse policy did not cover procedures to be followed if the Administrator was the staff person accused of abuse but the allegation would be called in to her supervisor.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: Guardians may not have any information about other individuals who reside at the facility and are not allowed to have free access to individuals' records.

Findings: An unannounced on-site complaint investigation was conducted from 8/25/08 through 8/29/08. During that time, review of the facility's policies and procedures and interviews with facility staff were completed with the following results:

The facility's Client Requests to Review and Copy Their Own Information policy, dated 4/18/06, included procedures to be followed when requesting information. The facility's newsletter, dated 8/22/08, contained an article that referenced the policy and stated guardians could not have unsupervised access to any records and could not have information about other clients that reside at the facility.

When asked, the Administrator stated during an interview on 8/24/08 from 12:00 - 12:35 p.m., the Client Requests to Review and Copy Their Own Information policy was in process of being revised to ensure all individuals' records were kept secure and individuals' rights to privacy and confidentiality were upheld.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #4: The HRC members' affiliation with administrative staff presents a conflict of interest.

Findings: An unannounced on-site complaint investigation was conducted from 8/25/08 through 8/29/08. During that time, the facility's Human Rights Committee and interviews with facility staff were completed with the following results:

During the entrance conference on 8/25/08 from 10:15 - 10;35 a.m., the Administrator and Program Director were asked about the facility's Human Rights Committee. The Administrator stated the HRC's role had been expanded to include a sub-committee and collectively it would be a community-based committee to eliminate conflicts of interest.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Individuals elope from the facility.

Findings: An unannounced on-site complaint investigation was conducted from 8/25/08 through 8/29/08. During that time, review of the facility's policies and procedures, Significant Event Reports, Minor Injury reports, investigations, individuals' records, observations, and interviews with facility staff were completed with the following results:

The facility's policies, titled Abuse Prevention (dated 4/11/08), Enhanced Supervision (dated 4/22/08), and Client Significant Event Reporting (dated 1/4/08) were compared and found to be inconsistent with each other. Collectively, the policies allowed individuals to be out of sight and unsupervised from 5 to 15 minutes with no requirement to report, document, or investigate the incident(s), depending on whether the individual eloped from the area, eloped from the campus, or was left unattended. For example, the Enhanced Supervision policy stated staff in the area were to know where the individual was at all times. However, the Client Significant Event Reporting policy stated the individual had to be missing 15 minutes or longer before it had to be reported. Neither of the two policies met the definition of neglect identified in the Abuse Prevention policy.

No less than 10 individuals were selected for review. Ten of the individuals' records documented they (the individuals) engaged in elopement behavior with the following results:

- One individual eloped from the campus the evening of 8/21/08 and was missing for no less than 1 hour 40 minutes. An investigation was not conducted.

- One individual eloped from the living unit and was missing for approximately 1 hour 13 minutes. The incident was not thoroughly investigated and appropriate corrective action was not taken. Further, the individual did not have a functional assessment, objective, or plan related to elopement behavior.

- One individual engaged in elopement behavior. The individual did not have a functional assessment, objective, or plan related to elopement behavior.

Interviews were conducted with direct care and management staff throughout the investigation. Direct care staff reported individuals eloped from the living unit or facility. Management staff reported some of the individuals did not have functional assessments, objectives, or plans related to elopement behavior.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

IDAHO DEPARTMENT OF
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P.O. Box 83720
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PHONE 208-334-6626
FAX 208-364-1888

October 27, 2008

Susan Broetje, Administrator
Idaho State School & Hospital
1660 11th Avenue North
Nampa, ID 83687

Re: Informal Dispute Resolution Conference, October 22, 2008
Idaho State School & Hospital

Dear Ms. Broetje:

Attached are the findings of the Informal Dispute Resolution Panel's decision.

Enclosed you will find the amended survey report. Please resubmit the facility's Plan of Correction for the remaining deficiencies and return the 2567 to this office by **November 10, 2008**. This will become the facility's survey of record.

Should you have any questions or concerns please do not hesitate to contact me at (208) 334-6626. Thank you for your participation in this process.

Sincerely,

Debra Ransom

DEBRA RANSOM, R.N., R.H.I.T
Chief
Bureau of Facility Standards

COPY

DR/lj

Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DIRK KEMPTHORNE – Governor
KARL B. KURTZ – Director

Sue Broetje –Acting Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho Developmental Resource Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@idhw.state.id.us

November 6, 2008

Debbie Ransom, R.N., R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Enclosed you will find the Plan of Correction you asked us to resubmit for the 8/29/08 amended survey report.

If you have any questions, please call me at 442-2812.

Sincerely,

SBroetje

Susan Broetje
Administrative Director
Idaho State School & Hospital

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 08/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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W 000	INITIAL COMMENTS This report incorporates changes resulting from the Informal Dispute Resolution (IDR) process. The following deficiencies were cited during the complaint investigation. The surveyors conducting your survey were: Monica Williams, QMRP, Team Leader Matt Hauser, QMRP Jim Troutfetter, QMRP Common abbreviations/words used in this report are: BRF - Behavior Reporting Form CFA - Comprehensive Functional Assessment DCS - Direct Care Staff DON - Director of Nursing HIS - Human Interaction System HRC - Human Rights Committee IED - Intermittent Explosive Disorder IEP - Individual Educational Plan LPN - Licensed Practical Nurse LWOP - Leave Without Permission OPFR - Observation, Plan of Action, Follow-up, Resolution PCP - Person Centered Plan PRN - As Needed PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional RN - Registered Nurse WIC - Written Informed Consent	W 000	RECEIVED NOV 10 2008 FACILITY STANDARDS	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		10/2/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

SBeeys — Administrative Director — 11/6/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for the individuals residing at the facility. This failure negatively impacted 16 of 17 individuals (Individuals #1 - #16) whose records were reviewed and had the potential to negatively impact all the individuals residing at the facility. Failure of the governing body to ensure these requirements were met resulted in individuals not being adequately supervised and protected and not receiving timely health care services in accordance with their needs, and the facility being found out of compliance with three (3) Conditions of Participation. The findings include: 1. The facility's Abuse Prevention policy, dated 4/11/08, did not include procedures to be followed if the Administrator was the staff person accused of abuse. Therefore, the policy did not identify who was responsible to perform no less than 7 duties that were assigned to the Administrator including immediate notification, determining whether abuse occurred based on the investigation report, ensuring appropriate corrective action was taken, working with outside providers, getting the written report, notifying personnel to return to work, and concluding the investigation. When asked, the Administrator stated during an interview on 8/24/08 from 12:00 - 12:35 p.m., the abuse policy did not cover procedures to be followed if the Administrator was the staff person accused of abuse but the allegation would be called in to her supervisor.	W 104		

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W 104	Continued From page 2 2. The facility's policies, titled Abuse Prevention (dated 4/11/08), Enhanced Supervision (dated 4/22/08), and Client Significant Event Reporting (dated 1/4/08) were compared and found to be inconsistent with each other. Collectively, the policies allowed individuals to be out of sight and/or unsupervised from 5 to 15 minutes with limited requirements to report, document, or investigate the incident(s), depending on whether the individual eloped from the area, eloped from the campus, or was left unattended, as follows: The Abuse Prevention policy, dated 4/11/08, stated "Neglect is the failure to provide goods and services necessary to avoid physical harm or mental anguish." Examples of neglect included "Failure to report any suspected abuse, exploitation, neglect, or threat" and "Failure to follow enhanced supervision guidelines." The Enhanced Supervision policy, dated 4/22/08, stated "...the staff in the area must know where the person is at all times..." However, the Client Significant Event Reporting policy, dated 1/4/08, stated if an individual eloped from the area or campus and was out of sight for less than 15 minutes, staff were to complete an SER and notify the Administrator. If an individual was out of sight 15 minutes or longer, it was to be reported as potential neglect. The Client Significant Event Reporting policy did not meet the definition of neglect identified in the Abuse Prevention policy or the Enhanced Supervision policy. Further, the Client Significant Event Reporting policy stated if an individual did not have	W 104		

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W 104	Continued From page 3 independent travel or required supervision in a restroom or isolated area, and was left unattended 5 minutes or longer, an SER was to be completed. The policy did not include procedures to be followed if an individual did not have independent travel or required supervision in a restroom or isolated area and was left unattended for less than 5 minutes. For example, Individual #13's QMRP reported during an interview on 8/28/08 from 10:00 - 10:30 a.m., Individual #13 was left unattended at a local bowling alley on 8/21/08 from approximately 9:31 - 9:34 p.m., a total of three (3) minutes. The QMRP stated she discovered this while speaking with staff the evening of 8/27/08. When asked, the QMRP stated the incident had not been documented and she was not sure how that was suppose to be documented. When asked, the Clinician stated during an interview on 8/28/08 from 4:32 - 4:45 p.m., Individual #13 should be within staff's "line of sight" while in the community. Additionally, when asked, the Recreational Supervisor stated during an interview on 8/28/08 from 4:10 - 4:21 p.m., Individual #13 should be in "line of sight" of staff and within arm's length while in the community. The Supervisor stated Individual #13's risk level to (sexually) re-offend was high due to his lack of participation in programming related to his sexual offenses. The survey team received a facsimile from the facility on 8/29/08 at 4:09 p.m., which showed Individual #13 was assessed on 8/28/08 and was at a "high" risk to re-offend. When asked during a follow-up telephone interview on 9/4/08 at 9:44 a.m., the Administrator stated there was no	W 104		

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W 104	Continued From page 4 investigation initiated because of the five minute rule. Additionally, the Client Significant Event Reporting policy stated if the length of time that staff were unaware that an individual was unsupervised and exceeded 15 minutes, the incident was to be reported as potential neglect. As stated, if staff were aware that an individual was unsupervised for 15 minutes or less, it would not be considered neglect which did not meet the definition of neglect identified in the Abuse Prevention policy or the Enhanced Supervision policy. The facility failed to ensure policies and procedures were adequately developed to ensure all individuals were appropriately supervised and free from potential neglect. 3. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals were not subjected to neglect and/or mistreatment. The facility was previously cited at W122 during an annual recertification survey dated 3/8/02, a follow up survey dated 6/28/02, a complaint investigation dated 4/24/03, a recertification survey dated 8/1/03, a recertification survey dated 6/19/06, a follow up survey dated 8/28/06, and a recertification survey dated 3/17/08. 4. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' services were sufficiently coordinated and monitored by the QMRP. The facility was previously cited at W159 during a follow up survey dated 11/8/02, a	W 104		

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W 104	Continued From page 5 complaint investigation dated 4/24/03, a recertification survey dated 8/1/03, a follow up survey dated 5/5/04, a follow up survey dated 8/26/04, a recertification survey dated 8/27/04, a recertification survey dated 3/29/05, a recertification survey dated 6/19/06, a follow up survey dated 8/28/06, a complaint investigation dated 9/20/06, a recertification survey dated 4/18/07, and a recertification survey dated 3/17/08. 5. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure program implementation plans included sufficient direction to staff. The facility was previously cited at W234 during a follow up survey dated 11/8/02, a recertification survey dated 8/1/03, a follow up survey dated 5/5/04, a follow up survey dated 8/26/04, a recertification survey dated 3/29/05, a recertification survey dated 6/19/06, a follow up survey dated 8/28/06, and a recertification survey dated 3/17/08. 6. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure programs described in PCPs were consistently and correctly implemented. The facility was previously cited at W249 during a recertification survey dated 3/8/02, a follow up survey dated 6/28/02, a follow up survey dated 11/8/02, a recertification survey dated 8/1/03, a follow up survey dated 5/5/04, a follow up survey dated 8/26/04, a recertification survey dated 3/29/05, a recertification survey dated 6/19/06, a follow up survey dated 11/16/06, a recertification survey dated 4/18/07, and a	W 104		

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W 104	Continued From page 6 recertification survey dated 3/17/08. 7. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure intrusive and/or restrictive interventions were conducted only with the written informed consent of individuals' guardians. The facility was previously cited at W263 during a follow up survey dated 5/5/04, a follow up survey dated 8/26/04, a follow up survey dated 8/28/06, a recertification survey dated 4/18/07, and a recertification survey dated 3/17/08. 8. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure plans incorporated the use of behavior modifying drugs. The facility was previously cited at W312 during a recertification survey dated 3/8/02, a complaint survey dated 4/24/03, a recertification survey dated 3/29/05, a recertification survey dated 6/19/06, a follow up survey dated 8/28/06, a complaint investigation dated 9/20/06, a recertification survey dated 4/18/07, a recertification survey dated 3/17/08, and a follow up survey dated 5/1/08.	W 104		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	W 153		

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W 153	Continued From page 7 Based on record review and staff interviews, it was determined the facility failed to ensure all allegations of neglect and/or mistreatment and injuries of unknown origin were immediately reported to the Administrator for 3 of 13 individuals (Individuals #13, #14, and #16) for whom such incidents occurred. This resulted in the potential for on-going neglect and/or mistreatment and injuries of unknown origin to occur without appropriate corrective action being taken. The findings include: 1. Individual #13's QMRP reported during an interview on 8/28/08 from 10:00 - 10:30 a.m., Individual #13 was left unattended at a local bowling alley on 8/21/08 from approximately 9:31 - 9:34 p.m., a total of three (3) minutes. The QMRP stated she discovered this while speaking with staff the evening of 8/27/08. When asked, the Clinician stated during an interview on 8/28/08 from 4:32 - 4:45 p.m., Individual #13 should be within staff's "line of sight" while in the community. Additionally, when asked, the Recreational Supervisor stated during an interview on 8/28/08 from 4:10 - 4:21 p.m., Individual #13 should be in "line of sight" of staff and within arm's length while in the community. The Supervisor stated Individual #13's risk level to (sexually) re-offend was high due to his lack of participation in programming related to his sexual offenses. The survey team received a facsimile from the facility on 8/29/08 at 4:09 p.m., which showed Individual #13 was assessed on 8/28/08 and was at a "high" risk to re-offend. When asked, the QMRP stated during the aforementioned interview, the incident had not been immediately reported to the Administrator.	W 153		

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W 153	Continued From page 8 The facility failed to ensure the Administrator was immediately notified when Individual #13 was left unattended at a local bowling alley. 2. A Client Minor Incident Report, dated 8/13/08, documented Individual #14 had three injuries of unknown cause. The Report stated he "possibly scratched self" on no less than three occasions including 8/13/08, 8/16/08, and 8/17/08. The 8/13/08 and the 8/16/08 injuries were noted to be on his head, and the 8/17/08 injury was noted to be on his face. No other details related to the unknown injuries were included in the Report. Further, there was no evidence of Administrator notification. When asked, the QMRP stated during an interview on 8/28/08 from 2:50 - 3:40 p.m., Individual #14's injuries had not been reported to the Administrator because they were minor incidents. The facility failed to ensure the Administrator was immediately notified of Individual #14's injuries. 3. A Client Minor Incident Report, dated 8/20/08, documented Individual #16 had an injury of unknown cause. The Report stated he "possibley [sic] scratched self " on his torso and right shoulder on 8/20/08 during the night. No other details related to the unknown injuries were included in the Report. Further, there was no evidence of Administrator notification. When asked, the QMRP stated during an interview on 8/28/08 from 2:50 - 3:40 p.m., Individual #16's injuries had not been reported to the Administrator because they were minor.	W 153		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 153	Continued From page 9 The facility failed to ensure the Administrator was immediately notified of Individual #16's injuries.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of investigations, minor injury reports, and staff interviews it was determined the facility failed to ensure all allegations of neglect and injuries of unknown origin were thoroughly investigated for 5 of 13 individuals (Individuals #1, #3, #11, #14, and #16) for whom such incidents occurred. This resulted in an absence of appropriate investigation and follow up to the incidents. The findings include: 1. Individual #11's PCP, dated 2/12/08, documented a 17 year old female diagnosed with mild mental retardation. An investigation, dated 8/13/08, documented that on 7/23/08, Individual #11 complained to an LPN that her right foot had been hurting for a few days and she wanted to see the Physician. The LPN documented the complaint on the Physician's Referral log but not on the RN Referral log. On 7/24/08, the Physician conducted rounds but did not see Individual #11. On 7/28/08, Individual #11 reported that her foot was still hurting to a second LPN who did not document the complaint on the Physician's Referral log or the RN Referral log. On 8/5/08, Individual #11 reported to a third LPN that her foot was still hurting. That LPN documented the complaint on the RN Referral log	W 154		

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W 154	Continued From page 10 and later that day, Individual #11 was seen by the Physician and a bedside x-ray was conducted. On 8/6/08, the x-ray report was received and showed Individual #11's 5th right metatarsal was broken. Individual #11 was seen by an orthopedic physician and a cast was applied to Individual #11's right foot. The investigation did not contain direct care staff interviews. When asked, the Investigator stated during an interview on 8/28/08 from 1:00 - 1:55 p.m., seven (7) staffs' handwritten statements came in the day the investigation report was written. The Investigator provided the statements to the surveyor during the interview and stated the staff statements were not included in the investigation because they did not provide any information related to how Individual #11 broke her foot. The RN's interview was contained in the investigation report and was dated 8/8/08. According to the RN's statement, she was informed of Individual #11's injury on 8/5/08 via the RN Referral log. However, according to the interview notes, the RN went on to explain what happened prior to the alleged date she was aware of the injury. Further, there was documentation on the Client Information log, Physician Referral log, and in Individual #11's OPFR charting. The investigation did not reflect that the RN was questioned as to how she knew about the incident, and why she did not read or monitor any of the aforementioned documents. The investigation did not contain an interview with Individual #11's physician. When asked, the Investigator stated during an interview on 8/28/08 from 1:00 - 1:55 p.m., the interview was	W 154		

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W 154	Continued From page 11 conducted and it must have been left out of the investigation. The surveyor received a copy of the interview at the exit conference on 8/29/08. The Physician's interview documented that on 7/23/08, a " ...Physician Referral was made which stated that [Individual #11] had pain in her foot. She (the Physician) referred it to the RN for assessment. When she (the Physician) was given a copy of the referral (which had been crossed out) she said I started to write have RN assess [sic] but only wrote 'Have R' then did not finish writing on [sic] referral sheet because she must have been distracted. When I asked her if it is common for her to refer an issue on the physician referral [sic] back to the RN for assessment. [sic] She stated that it should be on the RN referral first then put on the physician referral as a next step." However, the Detection and Assessment of Illness and Injury policy, dated 2/10/07, stated "Changes in health status which are stable and/or need routine physician follow [sic] will be placed in the physician referral book." Further, the investigation did not include information as to why Individual #11's request to see the physician was not honored. Under the Analysis of Findings section of the investigation, it stated the second LPN who did not document the complaint on the Physician's Referral log or the RN Referral log, did not follow the OPFR Charting policy and the Detection and Assessment of Illness and Injury policy. The investigation did not include pertinent information related to Individual #11's broken foot. Without a thorough investigation, the facility would be unable to determine appropriate	W 154		

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W 154	Continued From page 12 corrective action to prevent the reoccurrence of such an incidence. 2. Individual #1's PCP, dated 12/18/07, documented a 22 year old female diagnosed with mild mental retardation, schizoaffective disorder (bipolar type), and PTSD. An investigation, dated 8/15/08, showed that on 8/12/08 at 9:20 p.m., two (2) staff were on shift when Individual #1 left the living unit. The investigation stated one staff was completing her time sheet on the computer and the second staff was packing individuals' lunches for them. Individual #1's OPFR Charting, dated 8/12/08, was attached to the investigation which stated Individual #1 was missing for 5 minutes. A search for Individual #1 was initiated which included the campus and nearby streets, and the police were called as well. Individual #1 was found at 10:45 p.m. under a bush, outside her living unit. Individual #1 informed the nurse that she was upset and fell asleep. Attached to the investigation was a hand written statement, dated 8/12/08, that stated "At 10:45 (p.m.) I was told [Individual #1] was missing and I remembered where she hid last time and I went to bushes [sic] off the dining room in the back yard and she was curled up under the bush asleep and I yelled for Swing (evening staff) that she was found and I'm Noc (graveyard staff) and I was just coming [sic] on shift." Under the Analysis of Findings section of the investigation, it stated "The investigator found no fault to supervise nor was negligence found ..." When asked, the Lead Investigator stated during an interview on 8/24/08 from 1:00 - 1:55 p.m., the	W 154		

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W 154	Continued From page 13 staff who was on the computer was not asked about her personal time use and the second staff was not asked why she was packing lunches for individuals who were capable of doing the task themselves. Additionally, attached to the investigation was Individual #1's service plan for counseling, dated 1/12/07, which stated Individual #1 engaged in " ...leaving without permission." Individual #1's PCP did not contain objectives or instructions to staff related to elopement behavior. The investigation did not include this information. Further, interviews were conducted with graveyard staff on 8/25/08 12:10 - 12:35 a.m. During that time, staff reported Individual #1 engaged in elopement behavior, usually on swing shift, but she never left the campus. Staff stated she would hide in trees and it usually happened when she was angry. Additionally, a BRF, dated 8/13/08 at 11:00 p.m., documented Individual #1 "eloped" through the back gate and walked around campus then went to the rose garden. While at the rose garden, she made threats to present staff that "I will kill myself tonight" and "It's not my fault if I jump into traffic." The investigation did not include pertinent information related to Individual #1's elopement behavior. Without a thorough investigation, the facility would be unable to determine appropriate corrective action to prevent the reoccurrence of Individual #1's elopement behavior. 3. Individual #3's PCP, dated 6/5/08, documented a 50 year old male diagnosed with mild mental retardation.	W 154		

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W 154	Continued From page 14 An SER, dated 8/21/08, documented Individual #3 eloped from the facility at 11:50 p.m. and was found near a local car wash at 1:30 a.m. the following morning. No investigation of the incident was provided to the survey team. When asked, the Lead Investigator stated during a follow-up telephone interview on 9/4/08 at 9:36 a.m., he had no knowledge of an investigation being conducted. When asked, the Administrator stated during a follow-up telephone interview on 9/4/08 at 9:43 a.m., if the Lead Investigator did not have an investigation, then one was not conducted. The Abuse Prevention policy, dated 4/11/08, stated "Neglect is the failure to provide goods and services necessary to avoid physical harm or mental anguish." Examples of neglect included "Failure to follow enhanced supervision guidelines." The Enhanced Supervision policy, dated 4/22/08, stated "...the staff in the area must know where the person is at all times..." In sum, Individual #3 was without staff supervision for a period of 1 hour and 40 minutes and the facility failed to ensure an investigation was completed regarding the incident. 4. The facility's Client Minor Incident Reporting policy, dated 1/4/08, stated "For minor injuries of unknown cause, check the environment, client clothing, talk to staff, check past documentation, etc. and try to determine cause of the injury. Document the conclusion or hypothesis on the form." a. A Client Minor Incident Report, dated 8/13/08, documented Individual #14 had three injuries of	W 154		

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W 154	Continued From page 15 unknown cause. The Report stated he "possibly scratched self" on no less than three occasions including 8/13/08, 8/16/08, and 8/17/08. The 8/13/08 and the 8/16/08 injuries were noted to be on his head, and the 8/17/08 injury was noted to be on his face. No other details related to the unknown injuries were included in the report. When asked, the QMRP stated during an interview on 8/28/08 from 2:50 - 3:40 p.m., Individual #14's injuries had not been investigated. The facility failed to ensure Individual #14's injuries were investigated and documented as per the facility's policy. b. A Client Minor Incident Report, dated 8/20/08, documented Individual #16 had an injury of unknown cause. The Report stated he "possibley [sic] scratched self " on his torso and right shoulder on 8/20/08 during the night. No other details related to the unknown injuries were included in the Report. Further, there was no evidence of Administrator notification. When asked, the QMRP stated during an interview on 8/28/08 from 2:50 - 3:40 p.m., Individual #16's injuries had not been investigated. The facility failed to ensure Individual #16's injuries were thoroughly investigated and documented as per the facility's policy.	W 154		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by:	W 157		

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W 157	Continued From page 16 Based on review of investigations, minor injury reports, and staff interviews it was determined the facility failed to ensure appropriate corrective action was taken in response to alleged neglect and injuries of unknown origin for 2 of 13 individuals (Individuals #1 and #11) for whom such incidents occurred. This resulted in a lack of appropriate follow up to the incidents. The findings include: 1. Individual #11's PCP, dated 2/12/08, documented a 17 year old female diagnosed with mild mental retardation. An investigation, dated 8/13/08, documented that on 7/23/08, Individual #11 complained to an LPN that her right foot had been hurting for a few days and she wanted to see the Physician. The LPN documented the complaint on the Physician's Referral log but not on the RN Referral log. On 7/24/08, the Physician conducted rounds but did not see Individual #11. On 7/28/08, Individual #11 reported that her foot was still hurting to a second LPN who did not document the complaint on the Physician's Referral log or the RN Referral log. On 8/5/08, Individual #11 reported to a third LPN that her foot was still hurting. That LPN documented the complaint on the RN Referral log and later that day, Individual #11 was seen by the Physician and a bedside x-ray was conducted. On 8/6/08, the x-ray report was received and showed Individual #11's 5th right metatarsal was broken. Individual #11 was seen by an orthopedic physician and a cast was applied to Individual #11's right foot. The RN's interview was contained in the investigation report and was dated 8/8/08. According to the RN's statement, she was	W 157		

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W 157	Continued From page 17 informed of Individual #11's injury on 8/5/08 via the RN Referral log. However, according to the interview notes, the RN went on to explain what happened prior to the alleged date she was aware of the injury. Further, there was documentation on the Client Information log, Physician Referral log, and in Individual #11's OPFR charting. The investigation did not reflect that the RN was questioned as to how she knew about the incident, and why she did not read or monitor any of the aforementioned documents. The investigation did not contain an interview with Individual #11's physician. When asked, the Investigator stated during an interview on 8/28/08 from 1:00 - 1:55 p.m., the interview was conducted and it must have been left out of the investigation. The surveyor received a copy of the interview at the exit conference on 8/29/08. The Physician's interview documented that on 7/23/08, a " ...Physician Referral was made which stated that [Individual #11] had pain in her foot. She (the Physician) referred it to the RN for assessment. When she (the Physician) was given a copy of the referral (which had been crossed out) she said I started to write have RN assess [sic] but only wrote 'Have R' then did not finish writing on [sic] referral sheet because she must have been distracted. When I asked her if it is common for her to refer an issue on the physician referral [sic] back to the RN for assessment. [sic] She stated that it should be on the RN referral first then put on the physician referral as a next step." However, the Detection and Assessment of Illness and Injury policy, dated 2/10/07, stated "Changes in health status which are stable and/or need routine physician follow [sic] will be placed	W 157		

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W 157	Continued From page 18 in the physician referral book." Further, the investigation did not include information as to why Individual #11's request to see the physician was not honored. Under the Analysis of Findings section of the investigation, it stated the second LPN who did not document the complaint on the Physician's Referral log or the RN Referral log, did not follow the OPFR Charting policy and the Detection and Assessment of Illness and Injury policy. Under the Conclusion section of the investigation, it stated the investigator determined that neglect did not occur. An Administrative Review of Investigation form was attached to the investigation which stated the corrective action to be implemented with the second LPN was "Training or counseling to [LPN] on Policy 02.02 and Policy 200.03" and "Training and/or personnel action for nursing staff on Policy 200.03." When asked how the corrective action taken would prevent reoccurrence of a similar or like incident, the Investigator stated during an interview on 8/28/08 from 1:00 - 1:55 p.m., it wouldn't. When asked, the DON stated during an interview on 8/28/08 from 9:10 - 9:25 a.m., the Physician should have seen Individual #11 when she (Individual #11) requested it, the RN should have caught the incident on the Physician Referral log and Shift log, and the corrective action that was taken was not adequate; it did not address all the issues. The facility failed to ensure appropriate corrective action was taken to prevent the reoccurrence of such an incident.	W 157		

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W 157	Continued From page 19 2. An investigation, dated 8/15/08, showed that on 8/12/08 at 9:20 p.m., two (2) staff were on shift when Individual #1 left the living unit. The investigation stated one staff was completing her time sheet on the computer and the second staff was packing individuals' lunches for them. According to Individual #1's OPFR Charting, dated 8/12/08, Individual #1 was missing for 5 minutes. A search for Individual #1 was initiated which included the campus and nearby streets, and the local police were called as well. Individual #1 was found at 10:45 p.m. under a bush, outside her living unit. Individual #1 informed the nurse that she was upset and fell asleep. Attached to the investigation was a hand written statement, dated 8/12/08, that stated "At 10:45 (p.m.) I was told [Individual #1] was missing and I remembered where she hid last time and I went to bushes [sic] off the dining room in the back yard and she was curled up under the bush asleep and I yelled for Swing (evening staff) that she was found and I'm Noc (graveyard staff) and I was just coming [sic] on shift." Under the Analysis of Findings section of the investigation, it stated "The investigator found no fault to supervise nor was negligence found ..." When asked, the Lead Investigator stated during an interview on 8/24/08 from 1:00 - 1:55 p.m., the staff who was on the computer was not asked about her personal time use and the second staff was not asked why she was packing lunches for individuals who were capable of doing the task themselves. When asked about corrective	W 157		

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W 157	Continued From page 20 action, the Lead Investigator stated there was none as the investigation was unsubstantiated. However, attached to the investigation was Individual #1's service plan for counseling, dated 1/12/07, which stated Individual #1 engaged in " ...leaving without permission." Individual #1's PCP did not contain objectives or instructions to staff related to elopement behavior. Further, interviews were conducted with graveyard staff on 8/25/08 12:10 - 12:35 a.m. During that time, staff reported Individual #1 engaged in elopement behavior, usually on swing shift, but she never left the campus. Staff stated she would hide in trees and it usually happened when she was angry. Additionally, a BRF, dated 8/13/08 at 11:00 p.m., documented Individual #1 "eloped" through the back gate and walked around campus then went to the rose garden were she made threats to present staff that "I will kill myself tonight" and "It's not my fault if I jump into traffic." The facility failed to ensure corrective action was taken to prevent the reoccurrence of Individual #1's elopement behavior including appropriate staff monitoring and supervision, and objectives and program plans to address the behavior.	W 157		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by:	W 159		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 21 Based on record review and staff interviews, it was determined the facility failed to ensure the QMRP provided sufficient integration, monitoring, and coordination of the status of 16 of 17 individuals (Individuals #1 - #16) whose records were reviewed. That failure resulted in individuals not receiving the services and supports required to meet their needs. The findings include: 1. Individual #12's OPFR Charting, dated 8/13/08 at 9:00 a.m., stated "[Individual #12] had some vaginal bleeding this AM. She had a pap on 8/5/08. She was very uncoop. (uncooperative). This may be the cause. Will continue to monitor." When asked, the LPN stated during an interview on 8/28/08 from 2:20 - 2:30 p.m., Individual #12 was known to aggressively masturbate. When asked, the QMRP stated during an interview on 8/28/08 from 3:00 - 3:20 p.m., he was unaware of Individual #12's issues related to her masturbation and was not aware that she had vaginal bleeding on 8/13/08. 2. Refer to W111 as it relates to the facility's failure to ensure the QMRP maintained a record keeping system that contained accurate and complete information for individuals. 3. Refer to W122 - Condition of Participation for Client Protections and related standard level deficiencies as it relates to the facility's failure to ensure the QMRP provided sufficient oversight and monitoring to ensure individuals were not subjected to neglect and/or mistreatment, individuals were supervised in accordance with their needs, and assessments, objectives and program plans were adequately developed.	W 159		

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	13G001	A. BUILDING _____ B. WING _____	C 08/29/2008

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W 159	Continued From page 22 4. Refer to W214 as it relates to the facility's failure to ensure the comprehensive functional assessment identified individuals' specific behavioral management needs related to their elopement behavior. 5. Refer to W227 as it relates to the facility's failure to ensure objectives necessary to meet individual's needs were developed. 6. Refer to W234 as it relates to the facility's failure to ensure instructions to staff related to maladaptive behaviors were incorporated in plans. 7. Refer to W249 as it relates to the facility's failure to ensure individuals received needed interventions and services in sufficient number and frequency to support the achievement of objectives identified in their PCPs. 8. Refer to W260 as it relates to the facility's failure to ensure the QMRP updated individuals' PCPs. 9. Refer to W263 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the written informed consent of the individual's guardian. 10. Refer to W312 as it relates to the facility's failure to ensure individuals' program plans included specific objective criteria for the reduction of sleep and PRN behavioral medication. 11. Refer to W318 - Condition of Participation for Health Care Services and related standard level	W 159		

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W 159	Continued From page 23 deficiencies as they relate to the facility's failure to ensure the QMRP assured individuals' medical needs were not neglected.	W 159		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the comprehensive functional assessment identified the specific behavioral needs for 3 of 13 individuals (Individuals #1, #4 and #13) whose behavior support programs were reviewed. Without complete and comprehensive behavioral information, it would not be possible to ensure behavior intervention strategies were consistent with the individuals' needs. The findings include: 1. Individual #4's PCP, dated 12/5/07, documented a 41 year old male diagnosed with profound mental retardation. Individual #4's Comprehensive Functional Assessment, dated 12/5/07, stated "LWOP by history...This may be [Individual #4's] attempt to leave environments that are overly stimulating." However, Individual #4's active treatment schedule, undated, stated "[Individual #4] requires 'Heightened Supervision' this means he needs to be visually supervised at all times." His schedule further stated "[Individual #4] will leave the building without your knowledge; this is why visual supervision is so important." Additionally, Individual #4's OPFR Charting showed Individual	W 214		11/1/08

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W 214	Continued From page 24 #4 eloped from the unit on 5/3/08 and 7/8/08. Individual #4's record did not contain evidence of an updated assessment related to his elopement behavior. Further, his 12/5/07 assessment did not identify the function(s), antecedents, or potential causes which contributed to eliciting and/or sustaining Individual #4's elopement behavior. When asked, the Clinician stated during an interview on 8/28/08 from 9:51 - 9:56 a.m., she did not know the specifics of Individual #4's elopement behavior. The facility failed to ensure Individual #4's behavioral assessment was updated and included the function(s), antecedents, and potential causes which contributed to eliciting and/or sustaining his elopement behavior. 2. Individual #13's PCP, dated 10/28/07, documented a 25 year old male whose diagnoses included borderline intellectual impairment, Fetal Alcohol Syndrome, IED, and impulse control disorder. He had a history of sexually related offenses. Individual #13's CFA, dated 10/28/07, did not include information related to his current risk to sexually re-offend. When asked, the Clinician stated during an interview on 8/28/08 from 4:32 - 4:45 p.m., that a current risk assessment should have been completed as part of Individual #13's CFA because it was a part of his maladaptive behavior. However, the QMRP stated during an interview on 8/28/08 from 10:00 - 10:30 a.m., Individual #13 did not have a current risk assessment because he was not in the discharge	W 214		

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W 214	Continued From page 25 process. The survey team received a facsimile from the facility on 8/29/08 at 4:09 p.m., which showed Individual #13 was assessed on 8/28/08 and was at a "high" risk to re-offend. The facility failed to ensure Individual #13's functional assessment included comprehensive and specific information related to his risk to sexually re-offend. 3. Individual #1's PCP, dated 12/18/07, documented a 22 year old female diagnosed with mild mental retardation, schizoaffective disorder (bipolar type), and PTSD. An investigation, dated 8/15/08, showed that on 8/12/08 at 9:20 p.m., two (2) staff were on shift when Individual #1 left the living unit. Individual #1's OPFR Charting, dated 8/12/08, was attached to the investigation which stated Individual #1 was missing for 5 minutes. A search for Individual #1 was initiated which included the campus and nearby streets, and the police were called as well. Individual #1 was found at 10:45 p.m. under a bush, outside her living unit. Individual #1 informed the nurse that she was upset and fell asleep. Attached to the investigation was a hand written statement, dated 8/12/08, that stated "At 10:45 (p.m.) I was told [Individual #1] was missing and I remembered where she hid last time and I went to bushes [sic] off the dining room in the back yard and she was curled up under the bush asleep and I yelled for Swing (evening staff) that she was found and I'm Noc (graveyard staff) and I was just coming [sic] on shift."	W 214		

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W 214	Continued From page 26 Additionally, attached to the investigation was Individual #1's service plan for counseling, dated 1/12/07, which stated Individual #1 engaged in " ...leaving without permission." Further, interviews were conducted with graveyard staff on 8/25/08 12:10 - 12:35 a.m. During that time, staff reported Individual #1 engaged in elopement behavior, usually on swing shift, but she never left the campus. Staff stated she would hide in trees and it usually happened when she was angry. Additionally, a BRF, dated 8/13/08 at 11:00 p.m., documented Individual #1 "eloped" through the back gate and walked around campus then went to the rose garden. However, Individual #1's Functional Assessment, dated 8/1/08, did not include any information or analysis of her elopement behavior. When asked, the QMRP and Clinician both stated during an interview on 8/28/08 from 2:05 - 3:15 p.m., Individual #1's elopement was not a behavior but a consequence of her being angry. The facility failed to ensure a functional assessment of Individual #1's elopement behavior was completed.	W 214		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by:	W 227		11/1/08

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W 227	Continued From page 27 Based on record review and staff interviews it was determined the facility failed to ensure the PCP included objectives to meet the needs for 4 of 13 individuals (Individuals #1, #3, #4 and #12) whose behavior support programs were reviewed. This resulted in a lack of program plans designed to address the behavioral needs of individuals. The findings include: 1. Individual #4's PCP, dated 12/5/07, documented a 41 year old male diagnosed with profound mental retardation. Individual #4's active treatment schedule, undated, stated "[Individual #4] requires 'Heightened Supervision' this means he needs to be visually supervised at all times." His schedule further stated "[Individual #4] will leave the building without your knowledge; this is why visual supervision is so important." Additionally, Individual #4's OPFR Charting showed Individual #4 eloped from the unit on 5/3/08 and 7/8/08. However, Individual #4's QMRP Additional PCP Narrative for July 2008 stated "Elopement is not a target behavior for [Individual #4]." When asked, the Clinician stated during an interview on 8/28/08 from 9:51 - 9:56 a.m., there was no objective for Individual #4's elopement. The facility failed to ensure objectives were developed for Individual #4's elopement behavior. 2. Individual #3's PCP, dated 6/5/08, documented a 50 year old male diagnosed with mild mental retardation. Individual #3's record showed he received Abilify (an anti-psychotic drug) and Depakote (an	W 227		

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W 227	Continued From page 28 anticonvulsant drug). Additionally, his medication plan, dated 6/08, documented Individual #3's hours of sleep were contingent on an increase or decrease in both drugs. However, his record contained no objective for sleep. When asked, the QMRP stated during an interview on 8/28/08 from 11:00 - 11:31 a.m., Individual #3 had no objectives related to sleep. The facility failed to ensure objectives related to sleep were developed for Individual #3. 3. Individual #12's PCP, dated 8/5/08, stated she was a 57 year old female whose diagnoses included severe mental retardation, organic brain syndrome, dementia, and seizure disorder. Individual #12's OPFR Charting, dated 8/13/08 at 9:00 a.m., stated "[Individual #12] had some vaginal bleeding this AM. She had a pap on 8/5/08. She was very uncoop. (uncooperative). This may be the cause. Will continue to monitor." Individual #12's OPFR Charting, dated 8/13/08 at 11:15 a.m., stated "Note to above. This nurse not present to see vaginal bleeding, however from past history knowledge [Individual #12] tends to be very aggressive when it comes to 'private time'." When asked, the LPN stated during an interview on 8/28/08 from 2:20 - 2:30 p.m., Individual #12 was known to aggressively masturbate. However, Individual #12's PCP did not include objectives related to masturbation. When asked, the QMRP stated during an interview on 8/28/08 from 3:00 - 3:20 p.m., he	W 227		

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W 227	Continued From page 29 was unaware Individual #12 had issues related to masturbation and no objectives were developed. The facility failed to ensure objectives were developed to address Individual #12's masturbation. 4. Individual #1's PCP, dated 12/18/07, documented a 22 year old female diagnosed with mild mental retardation, schizoaffective disorder (bipolar type), and PTSD. An investigation, dated 8/15/08, showed that on 8/12/08 at 9:20 p.m., two (2) staff were on shift when Individual #1 left the living unit. Individual #1's OPFR Charting, dated 8/12/08, was attached to the investigation which stated Individual #1 was missing for 5 minutes. A search for Individual #1 was initiated which included the campus and nearby streets, and the police were called as well. Individual #1 was found at 10:45 p.m. under a bush, outside her living unit. Individual #1 informed the nurse that she was upset and fell asleep. Attached to the investigation was a hand written statement, dated 8/12/08, that stated "At 10:45 (p.m.) I was told [Individual #1] was missing and I remembered where she hid last time and I went to bushes [sic] off the dining room in the back yard and she was curled up under the bush asleep and I yelled for Swing (evening staff) that she was found and I'm Noc (graveyard staff) and I was just coming [sic] on shift." Additionally, attached to the investigation was Individual #1's service plan for counseling, dated 1/12/07, which stated Individual #1 engaged in " ...leaving without permission." Individual #1's	W 227		

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W 227	Continued From page 30 PCP did not contain objectives or instructions to staff related to elopement behavior. Further, interviews were conducted with graveyard staff on 8/25/08 12:10 - 12:35 a.m. During that time, staff reported Individual #1 engaged in elopement behavior, usually on swing shift, but she never left the campus. Staff stated she would hide in trees and it usually happened when she was angry. Additionally, a BRF, dated 8/13/08 at 11:00 p.m., documented Individual #1 "eloped" through the back gate and walked around campus then went to the rose garden. When asked, the Clinician and QMRP both stated during an interview on 8/28/08 from 2:05 - 3:15 p.m., Individual #1 did not have objectives related to elopement because eloping was not a behavior but a consequence of Individual #1 being angry. The facility failed to develop objectives related to Individual #1's elopement behavior.	W 227		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 3 of 13 individuals (Individuals #1, #4 and #12) whose behavior support plans were reviewed. This resulted in a lack of instructions to staff being included in individuals' programs. The findings include: 1. Individual #4's PCP, dated 12/5/07,	W 234		11/1/08

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W 234	Continued From page 31 documented a 41 year old male diagnosed with profound mental retardation. Individual #4's active treatment schedule, undated, stated "[Individual #4] requires 'Heightened Supervision' this means he needs to be visually supervised at all times." His schedule further stated "[Individual #4] will leave the building without your knowledge; this is why visual supervision is so important." Additionally, Individual #4's OPFR Charting showed Individual #4 eloped from the unit on 5/3/08 and 7/8/08. However, Individual #4's QMRP Additional PCP Narrative for July 2008 stated "Elopement is not a target behavior for [Individual #4]." When asked, the Clinician stated during an interview on 8/28/08 from 8:57 - 9:15 a.m., there was only an informal plan for Individual #4's elopement. The facility failed to ensure instructions to staff regarding Individual #4's elopement behavior were incorporated into a plan. 2. Individual #12's PCP, dated 8/5/08, stated she was a 57 year old female whose diagnoses included severe mental retardation, organic brain syndrome, dementia, and seizure disorder. Individual #12's OPFR Charting, dated 8/13/08 at 9:00 a.m., stated "[Individual #12] had some vaginal bleeding this AM. She had a pap on 8/5/08. She was very uncoop. (uncooperative). This may be the cause. Will continue to monitor." Individual #12's OPFR Charting, dated 8/13/08 at 11:15 a.m., stated "Note to above. This nurse not	W 234		

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W 234	Continued From page 32 present to see vaginal bleeding, however from past history knowledge [Individual #12] tends to be very aggressive when it comes to 'private time'." When asked, the LPN stated during an interview on 8/28/08 from 2:20 - 2:30 p.m., Individual #12 was known to aggressively masturbate. However, Individual #12's PCP did not include plans related to masturbation. When asked, the QMRP stated during an interview on 8/28/08 from 3:00 - 3:20 p.m., he was unaware Individual #12 had issues related to masturbation and no plans were developed. The facility failed to ensure instructions to staff related to Individual #12's masturbation were incorporated in to a plan. 3. Individual #1's PCP, dated 12/18/07, documented a 22 year old female diagnosed with mild mental retardation, schizoaffective disorder (bipolar type), and PTSD. An investigation, dated 8/15/08, showed that on 8/12/08 at 9:20 p.m., two (2) staff were on shift when Individual #1 left the living unit. Individual #1's OPFR Charting, dated 8/12/08, was attached to the investigation which stated Individual #1 was missing for 5 minutes. A search for Individual #1 was initiated which included the campus and nearby streets, and the police were called as well. Individual #1 was found at 10:45 p.m. under a bush, outside her living unit. Individual #1 informed the nurse that she was upset and fell asleep. Attached to the investigation was a hand written	W 234		

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W 234	Continued From page 33 statement, dated 8/12/08, that stated "At 10:45 (p.m.) I was told [Individual #1] was missing and I remembered where she hid last time and I went to bushes [sic] off the dining room in the back yard and she was curled up under the bush asleep and I yelled for Swing (evening staff) that she was found and I'm Noc (graveyard staff) and I was just coming [sic] on shift." Additionally, attached to the investigation was Individual #1's service plan for counseling, dated 1/12/07, which stated Individual #1 engaged in " ...leaving without permission." Individual #1's PCP did not contain objectives or instructions to staff related to elopement behavior. Further, interviews were conducted with graveyard staff on 8/25/08 12:10 - 12:35 a.m. During that time, staff reported Individual #1 engaged in elopement behavior, usually on swing shift, but she never left the campus. Staff stated she would hide in trees and it usually happened when she was angry. Additionally, a BRF, dated 8/13/08 at 11:00 p.m., documented Individual #1 "eloped" through the back gate and walked around campus then went to the rose garden. When asked, the QMRP stated during an interview on 8/28/08 from 2:05 - 3:15 p.m., missing client books were updated to include areas were individuals might go but there were no instructions incorporated into a formal plan to address Individual #1's elopement behavior. The Clinician, who was also present during the interview, stated Individual #1's elopement was not a behavior but a consequence of her being angry. The facility failed to ensure instructions to staff	W 234		

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W 234	Continued From page 34 related to Individual #1's elopement behavior were incorporated into a plan.	W 234		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure each individual received training and services consistent with their IPP for 1 of 11 individuals (Individual #2) whose PCPs were reviewed. This resulted in an individual not receiving counseling as specified in his PCP. The findings include: 1. Individual #2's PCP included a service plan for building social skills which was dated 11/30/07. Under the Status section of the plan, it stated "[Individual #2] has historically had difficulty developing and maintaining friendships. One of [Individual #2's] main goals identified in his Person Centered Plan is to have friends. [Individual #2] will need assistance to learn those skills associated with developing and maintaining friendships." The plan stated Individual #2 would be encouraged to attend weekly counseling. His record did not contain any progress noted related to weekly counseling. Additionally, his PCP included a service plan for	W 249		11/1/08

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W 249	Continued From page 35 counseling, dated 11/13/07, which stated "[Individual #2] displays mood symptoms and behaviors which may relate to a past history of abuse and mental illness. In an effort to assist [Individual #2] manage [sic] his mental health symptoms, and behaviors [sic] counseling with [sic] be offered to her [sic] on a weekly basis. The plan stated the Clinician would document and provide ongoing progress notes regarding therapy issues in Individual #2's record. There were no progress notes in Individual #2's record related to his counseling. When asked, the QMRP stated during an interview on 8/24/08 from 11:00 - 11:35 a.m., he was informed by the Clinician within the last couple of weeks that Individual #2 had a short attention span so there was not much to do with him. The facility failed to ensure Individual #2 was provided with counseling as identified in his PCP.	W 249		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure an individuals' PCPs were revised to accurately reflect and respond to their current needs for 2 of 11 individuals (Individuals #1 and #2) whose PCPs were reviewed. This resulted in individuals' PCPs not being revised to reflect their current educational, social, and behavioral needs. The	W 260		11/1/08

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W 260	Continued From page 36 findings include: 1. Individual #2's PCP, dated 11/13/07, documented a 19 year old male diagnosed with mild mental retardation, bipolar disorder (type 2; hypomania with psychotic symptoms), PTSD, IED, and organic brain problems secondary to a cerebellar stroke and frontal lobe stroke. a. Individual #2's PCP stated "[Individual #2] would like to continue his education through [a local school district]." Additionally, his program record included an IEP which was dated 1/10/08. On 8/29/08, the state agency received a facsimiled memo, dated 4/1/08, which stated Individual #2 was being removed from the school roster as he had not attended school since 3/18/08. b. Individual #2's PCP included a service plan for building social skills, dated 11/30/07, which stated he would be encouraged to attend the following classes: social skills, relationships, empowerment, Planned Parenthood, and weekly counseling. When asked, the QMRP stated during an interview on 8/24/08 from 11:00 - 11:35 a.m., Individual #2 moved to his current living unit around the first of July 2008 and attended a weekly work class, relationship class, and mental health class. When asked, the QMRP stated the classes currently held were not really related to the classes identified in his 11/13/07 PCP and the social skills service plan was in need of revision. The facility failed to ensure Individual #2's PCP was revised when his educational status and	W 260		

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W 260	Continued From page 37 social skills classes changed. 2. Individual #1's PCP, dated 12/18/07, documented a 22 year old female diagnosed with mild mental retardation, schizoaffective disorder (bipolar type), and PTSD. Individual #1's PCP included a service plan for counseling, dated 1/12/07, which stated "Behaviors that [Individual #1] engages in that are harmful to self include binging and purging; trying to kill herself by choking, hanging, cutting, drowning, overdosing...Other behaviors of concern include...firesetting, temper tantrums...seeking medical attention..." When asked, the Clinician stated during an interview on 8/24/08 from 2:05 - 3:15 p.m., the maladaptive behaviors listed above were by history (historical records) and the wording could be better. The facility failed to ensure Individual #1's counseling plan was revised to reflect her current maladaptive behaviors.	W 260		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of	W 263		

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W 263	Continued From page 38 10 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of a restrictive intervention. The findings include: 1. Individual #4's PCP, dated 12/5/07, documented a 41 year old male diagnosed with profound mental retardation. a. Individual #4's record included a WIC, dated 12/07, which stated Serax (an anti-anxiety drug), Nitrous Oxide (a sedative drug), and physical restraint including the use of an adult restraint board, were to be used during medical and dental procedures. The WIC was signed by the guardian on 9/29/07, however, neither of the boxes were marked to indicate whether consent was or was not given. When asked, the Social Worker stated during an interview on 8/28/08 from 9:18 - 9:50 a.m., there was really no way to know if the consent was valid. b. Individual #4's record also included a WIC, dated 12/5/07, for the class approval of Seroquel, Abilify, Risperdal, and Geodon (anti-psychotic drugs) and for the use of physical restraint up to a two person HIS prone. The date of HRC approval was 12/28/07. A letter from the Social Worker to Individual #4's guardian, dated 2/08, documented guardian consent was not given for the 12/5/07 WIC. The letter stated "If you do not wish to consent, please contact us so that we may address your concerns." The 12/05/07 WIC contained a handwritten note that stated "The guardian has not responded to at	W 263		

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W 263	Continued From page 39 least 20 calls (and) registered mail was not picked up. Because it would be unethical to stop [Individual #4's] medications at this time consent is granted to continue with the program" [sic]. The approval for the 12/5/07 WIC was given by the Administrative Director on 2/29/08. When asked, the Social Worker stated during an interview on 8/28/08 from 9:18 - 9:50 a.m., she had no knowledge of the 2/08 letter and had not seen it before. The Social Worker stated she made phone contact with Individual #4's guardian on 3/13/08 and 7/30/08. When asked for documentation of the phone conversations, the Social Worker provided the surveyor with Social Service Progress Notes. The Social Service Progress Notes contained the following phone contacts that were made with Individual #4's guardian: 3/13/08, 5/08, 6/08, and 7/30/08. The Notes showed the content of the conversations were related to alternative placement and not consent for Individual #4's restrictive interventions. The facility failed to ensure guardian consent was obtained prior to the continued use of restrictive interventions.	W 263		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by:	W 312		11/1/08

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W 312	Continued From page 40 Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' PCPs that were directed specifically towards the reduction of and eventual elimination of the behavior for which the drugs were used for 2 of 10 individuals (Individuals #3 and #5) whose behavior modifying drugs were reviewed. This resulted in individuals receiving behavior modifying drugs without appropriate plans that identified drug usage and how they may change in relation to progress or regression. The findings include: 1. Individual #3's PCP, dated 6/5/08, documented a 50 year old male diagnosed with mild mental retardation. Individual #3's record showed he received Abilify (an anti-psychotic drug) and Depakote (an anticonvulsant drug). Additionally, his medication plan, dated 6/08, documented Individual #3's hours of sleep were contingent on an increase or decrease in both drugs. However, Individual #3's PCP contained no objective for sleep. When asked, the QMRP stated during an interview on 8/28/08 from 11:00 - 11:31 a.m., Individual #3 had no objective for sleep. The facility failed to ensure Individual #3's medication plan was adequately developed. 2. Individual #5's PCP, dated 7/22/08, documented a 14 year male whose diagnoses included pervasive developmental disorder, Asperger Syndrome by history, and oppositional defiant disorder.	W 312		

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W 312	Continued From page 41 Individual #5's Medication Plan, dated 7/22/08, stated he received Risperdal (an antipsychotic drug) by mouth PRN for assaultive behavior. If he refused to take Risperdal PRN by mouth, then a combination of Haldol (an antipsychotic drug) PRN and Benadryl (an antihistamine drug) PRN would be administered by injection. Individual #5's record contained no plan related to the use of the PRN drugs. When asked, the QMRP stated on 8/28/08 at 3:26 p.m., there was no plan. The facility failed to ensure a plan to related to the use of Risperdal PRN, Haldol PRN, and Benadryl PRN was developed for Individual #5.	W 312		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on review of investigations, record review, and staff interviews it was determined the facility failed to ensure necessary health care assessments, monitoring and timely follow up occurred. This resulted in delayed identification, treatment, and follow up of serious medical conditions. The findings include: 1. Refer to W322 as it relates to the facility's failure to ensure individuals received general and preventative care in accordance with their needs.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and	W 322		

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W 322	Continued From page 42 general medical care. This STANDARD is not met as evidenced by: Based on review of investigations, record review, and staff interviews it was determined the facility failed to ensure general care was provided to 2 of 12 individuals (Individuals #11 and #12) whose medical records were reviewed. This failure resulted in individuals not receiving timely health care services in accordance with their needs. The findings include: 1. Individual #11's PCP, dated 2/12/08, documented a 17 year old female diagnosed with mild mental retardation. An investigation, dated 8/13/08, documented that on 7/23/08, Individual #11 complained to an LPN that her right foot had been hurting for a few days and she wanted to see the Physician. The LPN documented the complaint on the Physician's Referral log but not on the RN Referral log. On 7/24/08, the Physician conducted rounds but did not see Individual #11. On 7/28/08, Individual #11 reported that her foot was still hurting to a second LPN who did not document the complaint on the Physician's Referral log or the RN Referral log. On 8/5/08, Individual #11 reported to a third LPN that her foot was still hurting. That LPN documented the complaint on the RN Referral log and later that day, Individual #11 was seen by the Physician and a bedside x-ray was conducted. On 8/6/08, the x-ray report was received and showed Individual #11's 5th right metatarsal was broken. Individual #11 was seen by an orthopedic physician and a cast was applied to Individual #11's right foot.	W 322		

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W 322	Continued From page 43 The RN's interview was contained in the investigation report and was dated 8/8/08. According to the RN's statement, she was informed of Individual #11's injury on 8/5/08 via the RN Referral log. However, according to the interview notes, the RN went on to explain what happened prior to the alleged date she was aware of the injury. Further, there was documentation on the Client Information log, Physician Referral log, and in Individual #11's OPFR charting. The investigation did not reflect that the RN was questioned as to how she knew about the incident, and why she did not read or monitor any of the aforementioned documents. The investigation did not contain an interview with Individual #11's physician. When asked, the Investigator stated during an interview on 8/28/08 from 1:00 - 1:55 p.m., the interview was conducted and it must have been left out of the investigation. The surveyor received a copy of the interview at the exit conference on 8/29/08. The Physician's interview documented that on 7/23/08, a " ...Physician Referral was made which stated that [Individual #11] had pain in her foot. She (the Physician) referred it to the RN for assessment. When she (the Physician) was given a copy of the referral (which had been crossed out) she said I started to write have RN assess [sic] but only wrote 'Have R' then did not finish writing on [sic] referral sheet because she must have been distracted. When I asked her if it is common for her to refer an issue on the physician referral [sic] back to the RN for assessment. [sic] She stated that it should be on the RN referral first then put on the physician referral as a next step."	W 322		

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W 322	Continued From page 44 However, the Detection and Assessment of Illness and Injury policy, dated 2/10/07, stated "Changes in health status which are stable and/or need routine physician follow [sic] will be placed in the physician referral book." Further, the investigation did not include information as to why Individual #11's request to see the physician was not honored. Under the Analysis of Findings section of the investigation, it stated the second LPN who did not document the complaint on the Physician's Referral log or the RN Referral log, did not follow the OPFR Charting policy and the Detection and Assessment of Illness and Injury policy. Under the Conclusion section of the investigation, it stated the investigator determined that neglect did not occur. An Administrative Review of Investigation form was attached to the investigation which stated the corrective action to be implemented with the second LPN was "Training or counseling to [LPN] on Policy 02.02 and Policy 200.03" and "Training and/or personnel action for nursing staff on Policy 200.03." When asked, the DON stated during an interview on 8/28/08 from 9:10 - 9:25 a.m., Individual #11 did not receive adequate health care services related to her foot The DON stated the Physician should have seen Individual #11 when she (Individual #11) requested it, the RN should have caught the incident on the Physician Referral log and Shift log, and the corrective action that was taken was not adequate; it did not address all the issues. In sum, Individual #11 reported pain in her right	W 322		

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W 322	Continued From page 45 foot and her concern was not adequately addressed for 14 days, at which point, her foot was x-rayed and found to be broken. The Physician failed to honor Individual #11's request to be seen, the RN failed to monitor Individual #11's heath status, and the LPNs failed to adequately communicate and document Individual #11's concerns to the RN and Physician. The facility failed to ensure appropriate and timely health care services were provided to Individual #11. 2. Individual #12's PCP, dated 8/5/08, stated she was a 57 year old female whose diagnoses included severe mental retardation, organic brain syndrome, dementia, and seizure disorder. Individual #12's OPFR Charting, dated 8/13/08 at 9:00 a.m., stated "[Individual #12] had some vaginal bleeding this AM. She had a pap on 8/5/08. She was very uncoop. (uncooperative). This may be the cause. Will continue to monitor." Individual #12's OPFR Charting, dated 8/13/08 at 11:15 a.m., stated "Note to above, this nurse not present to see vaginal bleeding, however from past history knowledge [Individual #12] tends to be very aggressive when it comes to 'private time'." Individual #12's OPFR Charting Note, dated 8/28/08, which stated "Late entry made to clarify documentation on 8/13/08 @ 0900. DCS, [staff's name] was re-interviewed by this nurse on this date @ 1509 (3:09 p.m.). [Staff's name] reports 'I got [Individual #12] up to the bathroom. There was no blood or anything unusual on the bedding.	W 322		

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W 322	Continued From page 46 I was putting on her socks and shoes, when I heard a plop in the toilet. When [Individual #12] got up there was blood in the toilet (described as the color that you would see on a pad when your [sic] on your mensus [sic]). There was a drip of blood on her L (left) inner thigh. I washed it off and there was no further bleeding present. I looked and did not see any BM (bowel movement) in the toilet' unquote [sic]. Staff had flushed the commode so this was not visualized by this nurse. This information was placed on Alert Charting, and on the Campus Nurse report for follow up in case there were further problems. [Individual #12] did not have any further problems on this shift." When asked, the LPN stated during an interview on 8/28/08 from 2:20 - 2:30 p.m., Individual #12 was post-menopausal and did not have vaginal spot bleeding. Individual #12's record was not reflective of receiving a direct visual assessment by nursing staff to determine the cause, source and severity of bleeding nor adequate monitoring and oversight related to her vaginal bleeding. The facility failed to provide Individual #12 with appropriate health care services such that the cause, source and severity of bleeding could be ascertained and resolved.	W 322		

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M 000	16.03.11 Initial Comments This report incorporates changes resulting from the Informal Dispute Resolution (IDR) process.	M 000		
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W153, W154, and W157.	MM177		10/2/08
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrative Director

(X6) DATE: 11/6/08

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	08/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM212	Continued From page 1	MM212		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W249.	MM212		11/1/08
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W102 and W104.	MM520		10/2/08
MM537	16.03.11.210.01(b) Documentary Evidence Documentary evidence of the resident's progress and of his response to his habilitation program; This Rule is not met as evidenced by: Refer to W111.	MM537		10/2/08
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and	MM725		10/2/08

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MM725	Continued From page 2 initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729		11/1/08
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		11/1/08
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W318 and W322.	MM735		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MM855	Continued From page 3	MM855		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855		11/1/08
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W260.	MM861		11/1/08

Plan of Correction for 8-29-08 Survey

TAG #W214

Corrective action for examples:

1. Client #4 had not eloped for 8 months prior to 5/3/08. Although he did have a couple of elopements as noted in the survey report, they were minor in nature and none have occurred since 7/8/08. The activity schedule will be revised to reflect his current status, and his CFA will be reviewed and updated to ensure that it is accurate.
2. Individual #13 was assessed with the Carich-Adkerson Sex Offender Risk Assessment Scale and the Vermont Assessment of Sex-Offender Risk on 8/28/08. These assessments include such details as sexual intrusiveness, use of force, and amenability to treatment.
3. The functional assessment of Individual #1's elopement behavior will be updated to accurately reflect her behavior as separating to calm. While staff were not able to locate her in the investigated incident, typically she is within the vision of staff when she leaves. The function of this behavior will be documented in her chart more accurately.

Action for all potentially affected clients:

1. Treatment teams will audit CFAs and update to ensure that all are current.
2. The Clinical Supervisor will be trained to ensure that current functional assessments or analyses are completed for all targeted behaviors. Current will be defined as 1 year or less.

Monitoring to ensure deficient practice does not recur:

The Clinical Supervisor and/or Assistant Program Director will review all BSPs. Part of this process will be to ensure that functional assessments have been completed and are current.

Date when corrective action will be complete: 11/1/08

TAG #W227

Corrective action for examples:

1. The activity schedule and CFA of client #4 will be modified to reflect current status.
2. The sleep criterion will be deleted from Individual #3's BSP as it is not a valid measurement of the effectiveness of the medication. The med criteria (monitoring his sleep) for increase and decrease was for Depakote and Abilify which are both being used to treat his Schizoaffective Disorder Bipolar Type. They treat mania which is measured by the Young Mania Rating Scale and the criterion for medication change is tied to the score on that scale.
3. The team reviewed Individual #12 and her PCP, BSP, CFA, Intervention History, and interviewed staff who have worked with Individual #12. They found nothing to suggest that she engages in masturbation inappropriate to time and place, masturbation with objects, or masturbation to the point of injury. The one person quoted as saying that this client aggressively masturbates based that remark on one incident that she observed and attributed to masturbation over a year ago. It is uncertain whether this was actually masturbation. In any event, one observed instance does not constitute a history.
4. The Behavior Reporting Form for Individual #1 will be changed and staff will be trained to correctly identify elopement. By program definition, Individual #1 is not eloping; she is separating herself to calm down. Staff had been misidentifying her going out in the yard or to the other end of the building as elopement.

Action for all potentially affected clients:
QMRPs will be retrained to review for newly emerging or returning behaviors and will be given criterion to ensure appropriate prioritization of training objectives.

Monitoring to ensure deficient practice does not recur:
The Q's will review the SER and Minor Event reports monthly for patterns and consideration for the need to develop a new objective.

Date when corrective action will be completed: 11/1/08

TAG #W234

Corrective action for examples:
1. The CFA will be updated to reflect the current status which negates the need for an objective in this area for Individual #4.
2. The team reviewed Individual #12 and her PCP, BSP, CFA, Intervention History, and interviewed staff who have worked with Individual #12. They could find nothing to suggest that she engages in masturbation inappropriate to time and place, masturbation with objects, or masturbation to the point of injury. The one person quoted as saying that this client aggressively masturbates based that remark on one incident that she observed and attributed to masturbation over a year ago. It is uncertain whether this was actually masturbation. In any event, one observed instance does not constitute a history and the development of an objective for masturbation is not appropriate. Medical assessments will be completed, however, to assist in determining the cause of the bleeding.
3. The BRF and PCP for Individual #1's behavior will be updated to clearly define the behavior as escape rather than elopement with corresponding instructions to staff.

Action for all potentially affected clients:
See action for W227. Programs will be developed for any newly developed objectives.

Monitoring to ensure deficient practice does not recur:
The Performance Improvement Department will review 25% of the programs to ensure instructions to staff are adequate.

Date when corrective action will be completed: 11/01/08

TAG #W249

Corrective action for examples:
Counseling will be resumed with Individual #2, even if it's only a few minutes per session because of his short attention span. Sessions will expand based on Individual #2's ability to tolerate.

Action taken for all potentially affected clients:
Training will be provided for QMRPs on the need to ensure that all objectives and services are included on the monthly monitoring sheet and are implemented with sufficient frequency.

Monitoring to ensure deficient practice does not recur:
1. The Program Director or Assistant Program Director will verify that all QMRP reviews are completed and a sample will be reviewed for thoroughness each month.
2. The Performance Improvement Department will review at least 25% of the QMRP reports to ensure that they address implementation of both objective-based and service-based programs.

Date when corrective action will be completed: 11/1/08

TAG #W260

Corrective action for examples.
1. Proper documentation of Individual #2's discontinuation of school services for nonattendance will be entered in his chart.
2. The QMRP's report to surveyors when interviewed was erroneous. The social skills program was discontinued prior to Individual #2 moving to Aspen, and is so noted in the March QMRP narrative completed by the previous QMRP. However, it was not marked off in the PCP, but that has been corrected. Aspen did add a T-14 Participation program in July which updated the service program for participation which addresses Individual #2's needs.
3. Individual #1's counseling plan will be updated to reflect current status.

Action taken for all potentially affected clients:
1. All school correspondence will be filed in the client's chart and also documentation of the receipt of this correspondence will be documented in the QMRP monthly narrative.
2. Goal Coordinators will review all plans and ensure that they reflect the current status of the client. Revisions will be made as needed.

Monitoring to ensure deficient practice does not recur:
1. Changes in school and WITCO status will be added to the QMRP's monthly checklist.
2. The Performance Improvement Department will check for continuity of program implementation when a client transfers from one client service unit to another.

Date when corrective action will be completed: 11/1/08

TAG #W312

Corrective action for examples.
1. The sleep criterion will be deleted from Individual #3's BSP as it was not a valid measurement of the effectiveness of the medication. The med criteria (monitoring his sleep) for increase and decrease was for Depakote and Abilify which are both being used to treat his Schizoaffective Disorder Bipolar Type. They treat mania which is measured by the Young Mania Rating Scale and the criterion for medication change is tied to the score on that scale.
2. The instructions for staff about the conditions under which they should request a PRN chemical restraint for Individual #5 were in his BSP staff intervention plan dated 1/25/08. They are also being modified for clarity.

Action taken for all potentially affected clients:
Goals managers have been asked to review their programs to ensure that all psychotropic medications that are being used are included in the PCP.

Monitoring to ensure deficient practice does not recur:
Pharmacy will provide a list of all psychotropic medications that are being used to the Clinical Supervisor, updated monthly. New medications will be reflected on the list. The Clinical Supervisor will use this list to ensure that all medications are included in the client PCPs.

Date when corrective action was completed: 11/1/08